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Muslim views on mental health and psychotherapy

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\textbf{Objectives.} The aim of this research was to explore with a heterogeneous Muslim population their understanding of the concept of mental health and how any mental distress experienced by an individual can best be addressed.

\textbf{Design.} A qualitative approach was taken. Participants were interviewed, and data analysed thematically.

\textbf{Methods.} A sample of 14 Muslims was interviewed according to a semi-structured interview schedule. Participants were recruited via electronic mailing lists, and communications with local Muslim organizations. Interviews were transcribed verbatim, and data were analysed using thematic analysis.

\textbf{Results.} Thematic analysis identified seven operationalizing themes that were given the labels ‘causes’, ‘problem management’, ‘relevance of services’, ‘barriers’, ‘service delivery’, ‘therapy content’, and ‘therapist characteristics’.

\textbf{Conclusions.} The results highlight the interweaving of religious and secular perspectives on mental distress and responses to it. Potential barriers are discussed, as are the important characteristics of therapy, therapists, and service provision. Clinical implications are presented along with the limitations of this study and suggestions for future research.

There is a clear government drive in the UK towards universal inclusion in health service provision. It has been widely acknowledged that the history of black and minority ethnic (BME) groups within the health care system, particularly mental health care has been an unpleasant one. Health care practice has come under increased scrutiny over recent years, with the consistent message being that BME groups are under represented in voluntarily accessed services (such as out-patient talking therapies), and over-represented in non-voluntary services (such as in-patient care under section).

With respect to the under-representation of BME groups in voluntarily accessed mental health services, there are two general points of focus. Firstly, whether services are accessible and secondly, if they are, then are particular groups reluctant to access them? The general picture in relation to most minority groups is a combination of the two.
For example, issues such as reputations of institutionalized racism and the lack of mental health professionals from minority backgrounds have been identified as significant barriers to the access of mental health services by individuals from BME groups (Fernando, 1995). The marginalization of BME groups is also exemplified by the National Institute for Clinical Excellence (NICE) guidelines for mental health, which consistently point out that there is a lack of evidence of the effectiveness of talking therapies within different ethnic groups (for specific examples, see NICE guidelines on anxiety and depression).

After Christians, Muslims represent the largest religious grouping in the UK. According to census statistics, there are approximately 1.6 million Muslims in the UK, approximately 54% of whom were born outside of the UK. There are cultural and individual variations in practice, and some of the beliefs relating to Islam, as there are in any faith-group. However, there remains a connection through religion.

Within the current socio-political climate, where UK Muslims are increasingly portrayed negatively (Ameli, Mohammed Marandi, Ahmed, Kara, & Merali, 2007), the mental well-being of this minority group is particularly under threat. Empirical evidence suggests that this context may be having a significant effect on the general mental health of the Muslim population (Ali, Liu, & Humedian, 2004; Ali, Milstein, & Marzuk, 2005; Sheridan, 2006). Yet there remain significant limitations in the usefulness of current mental health services to UK Muslims.

In their work outlining some of the major issues in providing health care for people from a Muslim background, Sheikh and Gatrad (2000) argue that Muslim narratives are not necessarily understood within Western models of care. One view is that psychological difficulties such as depression and anxiety may be viewed from an Islamic perspective as indicative of an unsound spiritual heart, a viewpoint which is incongruent with the broadly secular models of Western health care (Sheikh & Gatrad, 2000).

The differences between Western and Islamic understandings of mental distress are mirrored in the help-seeking behaviours of the populations. Where the Western model extols the expertise of the health care professional, the Islamic way often draws upon prayer, religious leaders, and family for support (Khan, 2006). However, these forms of support are not necessarily mutually exclusive, if individuals can find utility in both conceptualizations of mental distress. Khan’s (2006) survey of 459 Muslims in America, highlighted the potential for health care provision to complement traditional care through participants’ repeated identification of the need for services. Nevertheless, Khan suggested this balance had not yet been achieved as the identification of need was not related to a subsequent uptake of services. Similarly, a recent UK study of 156 Muslims of Pakistani origin found a consistent lack of uptake of mental health services (Rethink, 2007). Seven reasons were identified for this, which covered both inaccessibility (e.g. language barriers/inadequate service provision) and reluctance to access (e.g. community likes to keep matters in the family).

Although relatively few, survey studies have offered a great deal of insight into the inequalities of mental health care provision to Muslim populations. However, a major problem with the predominantly quantitative studies, such as the ones outlined, is a distinct lack of the richness of data that can come from qualitative methodologies. This thrust towards broad categorization can lead to overgeneralization, which is problematic for any group as diverse as the Muslim population. Any theory which attempts to presents a Muslim ‘worldview’ will inevitably misrepresent a broad range of views and approaches to life. It could also be argued that quantitative studies fail to explore the nuances that may be imperative to the therapeutic relationship, both on an individual and systemic level.
The few qualitative studies, which have been conducted, have been able to expand on the findings of the quantitative research. Chew-Graham, Bashir, Chantler, Burman, and Batsleer (2002) analysed data from four focus groups and identified tensions between Western and Islamic understandings of distress. Chew-Graham et al. (2002) also highlighted that self-harm was commonly used as a coping strategy. Formal services were only accessed at the point of desperation, and perceptions of honour played an important role in this decision-making process. Youssef and Deane (2006), in their qualitative study of mental health service utilization by Arabic speakers, also built on quantitative findings to describe the general distrust and fear of formal services and the potential impact of shame and stigma.

The limited evidence available has shown that despite a perceived need for mental health services, they are not being accessed by many UK Muslims. Studies have not only identified obstacles presented by the structures and values of health care institutions but describe the great contrasts in conceptualizations of the nature of mental distress, and the appropriate ways to address this within Western and Islamic cultures. The aim of the current research is to advance on previous literature by exploring with a heterogeneous Muslim population, their understanding of the concept of mental health and how any mental distress experienced by an individual can best be addressed.

**Methods**

**Procedure**

Ethical approval was gained from the Lancaster University Institute of Health Research ethics committee. Potential participants were sought via three sources, university and Lancaster Islamic Society electronic mailing lists, and local Muslim organizations. Participants were asked to contact the researcher directly if they wished to take part in the research, and information on the study was sent out prior to arranging an interview with interested parties. At the interview, the information document was given again, opportunity offered for participants to ask any questions, and consent forms signed. One interview was conducted with each participant with the duration ranging from 45 to 90 min.

**Participants**

Eighteen people enquired about the research, 14 of whom chose to take part. No information is held on those who chose not to participate. Table 1 shows a breakdown of the participant details. Information was grouped, rather than represented individually to maintain anonymity. One of the interviews was conducted with a couple, as that was their preference, although their data were labelled separately. The majority of the participants were first generation migrants (N = 10), and represented a wide range of nationalities. There were an equal number of males and females, and ages ranged from 28 to 77, half of whom fell into the age banding 30–39. Pseudonyms were not given to participants as to attach nationally appropriate ones would enable the matching of quotes to the relevant participant, thus reducing anonymity. Therefore, they are labelled A to M in order of interview, with the couple labelled H1 and H2.

**Interview schedule**

A semi-structured interview schedule was developed, in accordance with relevant literature. However, the emphasis within interviews was on allowing participants to
lead the direction of interviews, with open questions used as prompts. This approach was taken due to the limited amount of published empirical research identified. The schedule was revised at two stages; through discussion between the researchers, prior to the ethics committee, and then following the ethics committee’s feedback.

The researchers’ context
Both researchers are white British non-Muslims, working within clinical psychology in the north-west of England. Both trained in the UK, and have an interest in culture and its potential impact in all areas of life, particularly mental health.

Analysis
All the data were collected prior to analysis. Interviews were transcribed verbatim and analysed thematically. Transcripts were line coded and themes developed through reading and re-reading the data. Themes were organized according to their operationalization (Marks & Yardley, 2004). This involves developing a hierarchical coding frame; categories, and subcategories are then represented by ‘chunks’ of text (Marks & Yardley, 2004, pp. 60–61). This process took place in a number stages at an inductive level (Bauer & Gaskell, 2000), during which the researchers attempted to explore the ‘nuances’ of frequent themes in greater depth (Huberman & Miles, 1994).

Two methods were employed to ensure rigour in analysis. The researchers reviewed themes at each stage. As the themes developed, they were regularly corroborated with the data and initial themes (Fereday & Muir-Cochrane, 2006). At the mid-point of data analysis, microscopic examination was conducted (Strauss & Corbin, 1998).
This technique aims to encourage an appreciation of semantics within textual analysis, and facilitate reflectivity within the researcher.

Development of the thematic map was an iterative and reflexive process beginning after the first stage of analysis and concluding when the final themes were established. In the later stages of analysis, a number of themes were collapsed at the subcategory level where appropriate in order to increase ‘internal homogeneity and external heterogeneity’ (Braun & Clarke, 2006, p. 91). As the final themes were decided upon and organized, the aim was to label them in a manner which captured the content of the accompanying narrative without ‘...just paraphrasing the content of the data extracts...' (Braun & Clarke, 2006, p. 92).

Results

The participants’ views on mental health and psychotherapy were organized into seven operationalizing themes. They were given the labels ‘causes’, ‘problem management’, ‘relevance of services’, ‘barriers’, ‘service delivery’, ‘therapy content’, and ‘therapist characteristics’. Figure 1 shows the thematic map developed from these themes, as well as the subthemes under each operational theme.

Causes

‘Causes’ refer to what the participants felt led to the development of mental health problems. The majority of participants identified the cause of mental health or psychological difficulties as being a reaction to life-events. Examples of this type of explanation included stress, drugs, not having something to rely on, and ignoring minor problems so that they became bigger:

My bipolar 2 was triggered by the stress (participant E).

Examples of the ‘religious’ causes included problems being a punishment from God, or having a supernatural aetiology such as witchcraft or jinn. At times participants offered multiple perspectives on the causes of problems. For example, participant K said that he partly believed in jinn as a cause, ‘maybe 5%’, but also highlighted ‘drug taking’ as a major factor contributing to mental health problems. Another example came from participant J who said that ‘bad things’ occur as a result of your own actions, but that ‘good things’ are from Allah.

‘Life is a test’ had positive connotations not present in the ‘religious’ subtheme. Instead, tests from Allah were seen as something accepted and managed with thanks and patience as a part of life on earth and in preparation for the afterlife:

Life is basically a test I am going through and I would like to pass this test, and in the process of passing this test is a lot of satisfaction (participant G).

Tests participants reported as having faced included mental health problems such as depression and anxiety, as well as other challenges such as bereavement and social deprivation.

Problem management

This theme includes data which highlights participants’ views on how they manage the problems they face in life. It includes religious and secular strategies, within and outside
of therapy. The theme also provided a link between ‘causes’ and ‘relevance of services’. ‘Religious responses’ were offered irrespective of whether people considered themselves to be a ‘good Muslim’ or not. For example, when asked how problems are typically dealt with, H2 said:

. . . We are not good Muslims, but during times of distress, the first thing that comes to mind is God (participant H2).

In speaking about referring to Islam during times of distress, participants spoke of how their religion ‘gives peace of mind’ (participant I), is something to which they ‘refer to in times of problems’ (participant A), ‘provides psychological relief’ (participant I), and helps by teaching them to show ‘submission to the will of Allah’ (Participant J), which in turn helps them to manage problems.

Participants spoke about direct communication with Allah, either through prayer, or less formal ‘talking’ to God (participant H1). One said that she had directly challenged God in times of significant distress, but continues to pray and have ‘100% trust in God’
(participant L) to help her manage problems. For others, religious forms of problem management were found through reading religious texts such as the Qur’an or Hadiths. Others spoke of ‘religious interventions’ such as Wudu, or seeking guidance from religious leaders.

The importance of family and friends was repeated throughout the interviews as a way of managing problems. For example, participant A said ‘we make decisions as a family’ and participant D commented that problems are dealt with ‘in-house’. It was often reported that whilst participants’ social circle or religion would be their first consideration in managing problems they still felt that ‘professional is best’ for ‘serious’ problems (participant B). Involving family was seen as mainly a positive feature, but participants also spoke of the potential for receiving poor advice by involving non-experts.

Some participants spoke of having been advised by their family to seek professional involvement, and one mother (participant M) said that she referred her children to mental health services. Participants also made references to religious texts, which recommend seeking knowledge from the best possible source ‘even if it is in China’ (participant B).

Where solutions were believed to be internally located, participants spoke of using ‘positive thinking’, or ‘inner-strength’ (participant F) to deal with problems, and making efforts to change things themselves. The primary form of ‘internal solutions’ presented was patience. Specific problems that were given as examples where participants had used ‘patience’ to manage them included the death of a child (participant D), work-related unhappiness (participants H2, B, and C), feelings of failure (participant A), homesickness (participant I), and depression (participant J).

**Relevance of services**

This theme refers specifically to how relevant participants felt mental health services and psychotherapy was to them. Comments included both religious and non-religious rationale, and provided an overlap between the ‘problem management’ and ‘relevance of services’ themes as indicated by these quotes:

You don’t need that (a psychologist) because you are talking to friends and family about it (participant H2).

Participants spoke about there being less of a need for professional assistance if you have a strong faith, and a belief that only God can help. Some participants said that accessing services felt like a betrayal of their religion or that it was a secular way of viewing things. ‘Divine will’ received the most attention from clients, which was expressed in a variety of ways as shown in the examples below:

No matter what calamity falls on me, the first thing I say to myself, because I believe in divine will, that it must have been pre-ordained by God (participant D).

. . . Whatever happens is from Allah, and so a creation of Allah cannot help (participant G).

The view that services were not relevant was not a unanimous viewpoint as evidenced by the subtheme of problem management, labelled ‘professional is best’. Positive indicators of the relevance of UK mental health services included their importance in

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1 Sayings and traditions of the Prophet Mohammed.

2 A ritualistic washing believed to purify the body and spirit. It is performed before prayers or handling the Qur’an, but participants in this research also spoke of performing Wudu outside of these parameters.
giving ‘room for somebody who needs help’ (participant J). At times this appeared particularly important where people felt they were ‘getting prejudice from our own community’ (participant M). In these situations, there was an emphasis on therapeutic services as a place where someone would ‘just sit and listen’ (participant M), or not have an ‘assumption about me and my life’ (participant L). For participant L, this was particularly important as she had experienced sexual and physical abuse from within her community, both from family and professionals.

**Barriers**

This theme contained comments that related to participants’ perspectives on the things that acted as barriers preventing them from accessing services. Some participants said that they would feel ashamed, embarrassed, or stigmatized if they were to access services:

...If one in family got disablement mentally boys, then they got nothing wrong with the girls, she is alright. But still the mainstream of the Muslim community look down on them (participant K).

Others said that to access services would imply that they had not been able to get satisfaction from their religion.

On a broader level, the subthemes ‘wider societal issues’ and the ‘fear of stereotyping’ by services also presented significant barriers. Participants spoke of issues such as 9/11, Islamaphobia, and media representations of Muslims. When linked directly to service provision some said that Muslims do not receive ‘talking therapies’ (participant K). Other comments under this subtheme were that people should not be treated different on the basis of culture, and that in some cases they were:

There is a very important point here about multiculturalism here. Cultural relativism basically, that to treat people differently, just because they come from a different culture (participant E).

In the subtheme of ‘it’s only for serious issues’, the comments were fairly similar; that problems should be resolved with the help of family and friends. Participants felt that services should only be approached in cases of serious mental illness. The language used varied slightly between participants; some used the term ‘serious’, others said ‘crazy’, ‘really abnormal’, or ‘severe’. Some also gave specific examples of what they meant by this, such as schizophrenia and severe depression.

The final subtheme was developed from the responses of participants who had had some form of contact with mental health services. As this was under the operational theme of ‘barriers’, it refers to negative comments. They primarily came from two participants. Participant M said that she had experienced ‘bullying’ and ‘raceism’ from services. Participant L said that she felt that mental health services are ‘stuck in time’, meaning that whilst other public sectors had evolved to keep up with contemporary society, health and social care services had not. She acknowledged that services were attempting to overcome this problem, but said that there needed to be more work done in this area.

**Service delivery**

The title of this theme is more familiar to professionals than service users, as it incorporates aspects of the data relating to service provision. The subthemes were
linked by their potential impact on service provision, for example, participant L said that
she had participated in public consultation programmes, but would like to know more
about what was being done after those consultations.

The ‘consultation’ subtheme, not only referred to consultations and public
involvement events, but also to the way some participants described mental health
professionals. They were often referred to as ‘consultants’, regardless of their
professional status. In addition to this, meetings with mental health professionals were
referred to as ‘consultations’, whether they were single meetings, ongoing therapy, or
telephone conversations. Participants who had accessed therapy in Islamic countries
said that these consultations could continue informally, despite not accessing regular
therapy anymore.

The role of general practitioners (G.Ps) was given particular attention by
participants. People said that there was a need for them to provide more information
on the subject of mental health and psychiatric medication. Participants spoke of the
physical symptoms associated with mental health problems, which made the G.P the
first point of contact for people when responding to these issues:

I think the first port of call that you would have, which was for me the G.P. You know the
G.Ps and practitioners need to recognize and be more aware (participant L).

I think it (information about mental health) should come from the G.P, and in different
languages so people can pick up and read about it (participant M).

As well as needing more information from G.Ps, participants said that mental health
services generally needed to be more visible and accessible. Participants spoke of the
importance of professionals integrating with the Muslim community, attending social
events, and providing services in places such as mosques, and community centres.
Participants reported having felt ‘isolated’ by statutory services (participant M), not
knowing how to access them or what services may be available:

Maybe the first step is very good if there are awareness that this kind of service are available
(participant A).

**Therapy content**

Regardless of whether they knew about what specific services may be available,
participants did have views on what the content of therapy should be. This was not
always a simple view of content either having a religious aspect or not. There was often
an interaction of views on both ‘religious aspects’ and other aspects that referred to the
‘therapeutic relationship’, as well as comments on the theme of ‘cultural sensitivity’,
which included views on therapy content, which did refer to culture, but not
necessarily religion.

When asked what the important aspects of therapy were, participants often
gave answers that reflected a range of subthemes, as shown by the quotes from
participant:

They (therapists) need to understand . . . to inculcate the thing into their clients, that
whatever happens is from Allah.

It is not important that they (therapists) are Muslim.

They need to show that they really respect our religion (participant G).
Similarly, participant B felt that religion would be an important aspect of therapy because it says something about who she is. She also made comments relating to the ‘therapeutic relationship’, such as recalling a consultation in which she was told that she had forgotten herself, and needed to make some changes in her life. She went on to say that this comment was pivotal in realizing that her therapist truly understood her needs.

This complexity was also reflected in the view from some participants that advice should be different for Muslim and non-Muslim clients. This was indicated by participant I, when asked what advice would be helpful to give, she said that for Muslims the advice should be ‘go and do Wudu and pray’, but this would not be the case for non-Muslims.

Comments from participants, which were allocated to the subtheme ‘religious aspects’ included the need to acknowledge that some things might be different for Muslims, such as the ways of managing problems as discussed above. Whereas ‘therapeutic relationship’ included dealing with physical things first, providing a place to talk openly, listening, and more directive aspects such as teaching techniques to deal with problems.

The final subtheme in ‘therapy content’ was ‘cultural sensitivity’. Participants commented that it would be helpful to train therapists from within the cultural group, because there was a lack of understanding of culture. Often this was linked to faith. Participant M had had contact with mental health services and said that ‘people don’t understand our culture and our faith’. Participant D had not had contact with services, but felt that if therapists knew about a client’s background and beliefs, it would help them to ‘ask the right kind of questions’.

**Therapist characteristics**

The final theme, ‘therapist characteristics’ incorporates data that highlights issues pertinent to the process and presentation of therapy. Participants spoke of reluctance among more ‘traditional or first generation’ Muslims to trust therapists, as they were not from the immediate family or social circle. There were other comments relating to a general tradition of mistrust. Participants who had accessed therapy and found it to be successful said that trust in their therapist was important in this process.

‘Trust’ provided an overlapping subtheme with some of the other subthemes under ‘therapist characteristics’. For example, participant B said:

> Trust in psychologists is very important. Sometimes, I think the consultant just by his or her behaviour makes a trust (participant B).

This quote indicates not only that trust is important, but also that the way the therapist expresses themselves can instil that trust. Other examples of comments that were categorized as therapist views included participant C who said that her ‘therapist’s approach’ to her problem was that it was not that big compared to others she came into contact with. Not all of the comments on ‘therapist’s approach’ were as specific as that. In some cases, it was implicit within a statement indicating the active role ‘therapist’s approach’ plays, as indicated by the comment below:

> I think that they (therapists) need to show that they really really respect our religion. Show it maybe in some way that they really respect Islam (participant G).

He went on to say that therapists informing clients of their own religious views could do this.
As the previous quote shows, some participants held the view that the religion of the therapist was important. For others, the religion was not as important as the ‘quality and professionalism’ of the therapist. Within this subtheme, participants said that knowing about the quality of a service prior to accessing it is important:

We’ve never been told about the quality of what’s inside (mental health services), so we do not know (participant A).

In my opinion, it (therapist) doesn’t have to be Muslim. That’s okay as long as he is professional in the field (participant J).

Participants spoke about the influence of their religion in this point also, saying that the Qur’an said that you should seek knowledge from the best source, regardless of where that is.

Finally, some participants spoke about their experiences of therapy, and it is important to note that the themes presented here, as with all thematic analyses have individual nuances for the participants involved. Table 2 shows the different levels of contact the participants had with mental health services. Reflections on these experiences included feeling the therapist filled ‘the hole in my family’ (participant C) and not liking ‘the behavioural approach’ (participant E).

Table 2. Participants’ contact with mental health services

<table>
<thead>
<tr>
<th>Level of contact with mental health services</th>
<th>Specific context</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Bereavement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Anxiety/depression</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Bipolar disorder</td>
<td>1</td>
</tr>
<tr>
<td>Indirect</td>
<td>Advocacy/public consultation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Family member receiving service</td>
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</tr>
<tr>
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<td>NA</td>
<td>6</td>
</tr>
</tbody>
</table>

Note. No participant in this study fell into more than one category.

Discussion

This research aimed to explore with a heterogeneous Muslim population, their understanding of the concept of mental health and how any mental distress experienced by an individual can best be addressed. Considered together, the seven themes that were constructed from the data provide a descriptive account of this cohorts’ understanding of key processes in the generation of mental distress and potential paths to healing.

Central to the results was the continued interweaving of religious and secular influences in participants’ account of mental distress and well-being. From articulating their understandings of the underlying causes of mental health difficulties, to conveying what they believed to be the most appropriate courses of action during difficult times, as well as who would be best placed to help them if they should need it, participants continuously examined how Western secular and Islamic religious beliefs could coexist. For some they remained mutually exclusive and seeking help from services would be considered a direct rejection of Allah. For others, mental health services and Islamic

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3 This participant used the term ‘he’ in a gender neutral manner, to refer to both men and women.
belief could be potentially complementary but a respect for and understanding of an individual’s religious beliefs was seen as essential for the therapeutic relationship to be valuable.

A lack of integration of these two viewpoints was linked to a number of different issues. Participants communicated the Muslim community’s powerful narratives of shame and stigma attached to the accessing of mental health services. The fact that many services seemed to have developed a culture which, consciously or otherwise, promotes the continued mutual exclusivity of these two belief systems was illustrated in participants’ accounts of everything from direct bullying and racism to the lack of information about services available in multiple languages.

Despite the difficulties assimilating two belief systems for some individuals, and the sizable barriers to accessing meaningful services for others, there was an impetus in people’s accounts to move towards a context where mental health services were truly universal. This was perhaps implicitly apparent in their initial decision to be part of the research process. Participants spoke of services that were ‘stuck in time’ and left individuals feeling isolated. The vision for the future, however, was of integration, beginning with the availability of good quality information to the physical presence of mental health practitioners within Muslim communities.

Regardless of whether participants had previously accessed mental health services or not, they were able to articulate characteristics of both the therapist and the therapeutic context that should be in place for therapy to be potentially helpful to them. Again, this implies that even for those expressing the intractable nature of the relationship between Western secular and Islamic religious views, there is a glimmer of hope that they can be assimilated within the therapeutic context. Regardless of the religion of the therapist themselves, participants argued for the meaningful and respectful centrality of an individual’s faith within the therapeutic process.

Quality
Qualitative researchers have recommended taking steps to ensure the quality of the study regardless of the chosen methodology (e.g. Barker & Pistrang, 2005; Silverman, 2000; Smith, 2008; Yardley, 2000). Some of the methods employed to ensure the quality of this research included; providing a trail of theme development, regular and detailed supervision, incorporating microscopic analysis, and summarizing individual interviews with participants during and at the end of each interview to check the interviewer’s accuracy of understanding.

However, it may also have been useful to incorporate ‘member checks’ (Lincoln & Guba, 1985) into this research. Member checks are a form of data triangulation and involve checking provisional findings with participants. The process takes place after the data have been collected during the development of themes. This can ensure that themes are consistent with the views participants were intending to express. However, the approach does not have a consensus of backing amongst qualitative researchers (Mays & Pope, 2000), and in this case was discounted for logistical reasons.

Clinical implications
There are specific societal issues facing Muslims today, and this was reflected in participants’ references to 9/11 and media representations of Muslims. It is important for professionals to be sensitive to the effect this may be having on the mental health of
some Muslims, and become more visibly available to this population. One method may be to adapt the traditional form of service provision, perhaps by increasing community services in mosques or community centres, or by clinicians acting as consultants to Imams and traditional healers.

The themes presented in this research may also be important in direct therapy. There were aspects from each theme which offer novel findings, when compared to previous literature. These included the range of religious and non-religious explanations of aetiology within ‘causes’, ‘fear of stereotyping’, and ‘wider societal issues’ within the service delivery theme. Other examples include the management of problems more generally, through patience and trusting in divine will.

Therapy may be made more sensitive to Muslim clients by incorporating some of these themes of patience, and prayer into individual and group work. There has already been the suggestion that approaches that incorporate a religious component may be useful (Abudabbeh & Hays, 2006; Al-Radi & Al-Mahody, 1989; Razali, Aminah, & Khan, 2002; Valiante, 2003). The range of therapies clinical psychologists have exposure to through training, presents the opportunity to explore their usefulness to Muslim clients. For example, it may be that therapies more grounded in Eastern approaches such as mindfulness or acceptance and commitment therapy are of particular benefit to this group because of their emphasis on acknowledgement and patience with psychological difficulties.

**Limitations and future research**
This research was limited by sample size, and cannot be viewed as representative of the Muslim population as a whole. However, the diverse make-up of this population should prevent any research making this claim. In addition, the qualitative nature of this research, presents a rich picture of the issues felt to be important to this sample. With respect to data analysis, the research did not incorporate additional validity checks such as member checking that may have added to the rigour of the study. However, steps were taken to ensure a rigorous analysis of the data took place.

Future research in this area should look to compare some of the themes in the present research, with samples from other religions. It may be that the themes are applicable to people who are from monotheistic faiths. The participants in this research expressed a connection with other Abrahamic faiths in particular. This suggests that samples from the Christian and Jewish faiths may be the first point of comparison. It may also be useful to consider the impact of other demographic factors within a Muslim population, such as age, gender, and nationality.

Another option may be to explore the views of Muslims who have accessed services. Some of the participants here had utilized mental health services, but differentiation was not made between them when analysing the data. One option could be to use the themes from this and other literature in a deductive form of analysis. Given the contextual aspect to the data collected here, it may be useful to conduct research which aims to specifically explore the experiences of members of the Muslim population who have accessed services.

**Conclusions**
Given the dearth of empirical research that has been published with a Muslim population in the UK, this research provides a useful addition to the literature base. The themes developed covered areas relating to mental health and psychology,
and have potential clinical implications for work with Muslim clients, as well as future research. The findings from this research also show that it is possible to yield useful findings from groups linked by religion, whilst also allowing for individual differences within the group.

References


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